mti physical therapy
PROVIDING ONE-TO-ONE CARE

Client Information Form - Craniosacral Therapy

Name: _____ Birth Date: _____
Address: _____ City _____ State _____ Zip _____
Preferred Contact Method: **o** (Cell) _____ **o** (E-mail) _____
Occupation: _____
Referred by: _____
Emergency contact person: _____ Phone: _____

oYes o No Have you previously experienced Craniosacral Therapy?
oYes o No Are you currently under a physician's care for any condition? Please describe: _____
_____
Physician's name: _____ Phone: _____ Fax:_____
Primary reason for today's visit, (please explain):_____
_____
Areas of complaint, pain, tension, (please explain): _____
_____
In a few words, please describe your goal for this session: _____
_____
Are you aware of any emotional distress from the time of an injury?: _____
_____
Have you suffered any form of abuse your body may be holding?: _____
_____

Please answer the following questions:
oYes o No Do you wear contact lenses?
oYes o No Do you wear dentures?
oYes o No Have you had extensive dental work (ie; braces, etc.)?
oYes o No Car accident (at any time), serious falls or injuries?
oYes o No Do you have any allergies? If so, please describe allergens:
_____
oYes o No Do you have arthritis? What type and where? Please describe_____
_____
oYes o No Do you have any heart problems? Please describe:_____
_____
oYes o No Do you have any spinal problems? Please describe:_____
_____
oYes o No Are you presently pregnant? How far along? Complications?_____
_____
oYes o No Have you had surgery? How recently? Complications?_____
_____
oYes o No Do you take any prescribed medications? Please list:_____
_____

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oYes o No Do you exercise or play sports on a regular basis? Please describe: _____
_____

oYes o No Are you receiving any other complementary care currently, (chiropractor, naturopathic, acupuncture, nutritional, herbal, homeopathic, hypnotherapy)? If so, please describe:_____
_____

oYes o No Do you have any other physical or mental condition of which I should be aware before giving you a Craniosacral session? If yes, please describe:_____
_____

Please read and initial:

____ I understand that the Craniosacral therapist does not diagnose illness, disease, or any other physical or mental disorder. In addition, the Craniosacral therapist does not prescribe medical treatment or pharmaceuticals

____ I am not currently experiencing any of these conditions: recent injuries to the head and neck, ie; recent whiplash, any recent fracture to base of the neck, concussion, hemorrhage, as well as rheumatoid arthritis

____ I am aware that Craniosacral therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

____ Because a Craniosacral therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the Craniosacral therapist updated on my physical health. Further, I release the therapist from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.

Signature: _____Date: _____

I have completed the above information accurately and have read, understand, and take responsibility for the above statements.

Therapist Notes: